OVERVIEW

OF THE

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

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DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

The Department of Medical Assistance Services (DMAS) is one of eleven (11) agencies within the Health and Human Resources Secretariat. The Department is composed of the Agency Director, Chief Deputy Director, two Deputy Directors and fifteen (15) separate divisions. Currently, there are 349 funded classified positions, along with wage and contract employees. The following information describes the key functions of the Department.

MISSION STATEMENT

To provide a system of high quality and cost effective health care services to qualifying Virginians and their families.

OFFICE OF THE DIRECTOR

INTERNAL AUDIT DIVISION

The mission of the Internal Audit Division is to independently examine and evaluate the ongoing control processes of the Agency and to provide counsel and recommendations for improvement whenever such opportunities are identified. The objective of the Division is to provide reasonable assurance to management, within economic limitations and subject to the availability of staff that:

- Internal accounting controls are adequate and effective in promoting efficiency and in protecting the assets of the Department;
- Financial statements and reports, whether for internal or external use, comply with established policies, generally accepted accounting principles, and/or other applicable rules and regulations both State and Federal;
- Operational policies that promote the well-being of the Department are effective and enforced to the end that operational efficiency and effectiveness are achieved;
- Adequate standards of business conduct are being observed;
- Internal control over automated data processing activities is sufficient to reasonably assure efficient, accurate, and complete processing of Department data with due regard to security.
- All instances of fraud, waste and abuse discovered through the audit process are fully investigated and reported on a timely basis.
- Auditing DMAS' compliance with the provisions of the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The scope of work of the Internal Audit division is to ascertain that the organization's network of control processes, as designed and represented by management, is adequate and functioning in a manner to ensure:

- Significant financial, managerial, and operating information is accurate, reliable and timely;
- Employee's actions are in compliance with policies, standards, procedures, and applicable laws and regulations;
- Resources are acquired economically and used efficiently;
- Programs, plans, and objectives are achieved;
- Quality and continuous improvement are fostered in the organization's control process.

Opportunities for improving the use of state/federal funds and for improving the image of the organization may be identified during audits and consulting projects; they will be communicated to the appropriate level of management.

HUMAN RESOURCES DIVISION

The Division of Human Resources is responsible for providing human resource management and development for the Department. Primary responsibilities are to support employees of the Department in the areas of employee relations, classification, compensation, employee benefits, recruitment and selection, employee recognition, workers' compensation, human resource policies, procedures and employee training. In addition, the division is responsible for processing and maintaining employee leave records and the official employee files. Other programs such as the Deferred Compensation, CommonHealth, Savings Bonds, Pre-tax Saving programs and other programs are made available to employees. Payroll and leave processing is coordinated through the Payroll Service Bureau at the Department of Accounts.

OFFICE OF COMPLIANCE AND SECURITY

The mission of the Office of Compliance and Security (OCS) is to provide guidance to all DMAS administrative and operational Divisions to mitigate risks to the confidentiality, integrity, and availability of all DMAS information and to ensure compliance with all applicable federal and state legislation. OCS is responsible for planning, governance, incident reporting, and oversight of a comprehensive privacy, information, and physical security program for the Department, to include:

- Maintaining a Risk Management plan in compliance the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule and requirements of the Virginia Information Technology Agency (VITA);
- HIPAA compliance through management of the OCS Privacy Office;
- Governance and policy responsibility for Information Security Officer (ISO) functions for the security of all DMAS information to comply with all security policies and standards of VITA;
- Security Awareness training for HIPAA and Information Security and training for the DMAS Code of Ethics and Business Conduct;
- Management of the Department's Continuity of Operations (COOP) Plan;

- Compliance with the DMAS Code of Ethics and Business Conduct; and
- Serving as the Chairperson for the Security Advisory Council

OFFICE OF THE CHIEF DEPUTY DIRECTOR

MATERNAL AND CHILD HEALTH DIVISION

The Maternal & Child Health Division promotes enrollment of eligible children and pregnant women in Medicaid, FAMIS, FAMIS MOMS and FAMIS Plus programs. The division administers the State Children's health Insurance Program (SCHIP), entitled FAMIS (Family Access to Medical Insurance Security) in Virginia as well as special health care services for all covered children and pregnant women. Responsibilities of the division are generally divided into the following functions:

MARKETING AND OUTREACH

Staff of the division conducts marketing and outreach statewide to promote the child health insurance programs and coverage for pregnant women. This work is conducted in coordination with many community and private sector partners as well as with other state agencies, businesses, and provider groups.

In addition, the division manages contracts with a public relations firm to develop and conduct media campaigns and with the Virginia Health Care Foundation to support local outreach projects in high-need areas and provide training to community programs statewide. Division staff also creates and disseminates promotional print material, maintains an interactive web site and organizes special events to educate the public and promote enrollment.

OPERATIONS

The division administers the FAMIS Central Processing Unit (CPU), through a contract, to maintain a statewide toll-free call center and application-processing site for FAMIS, FAMIS Plus, FAMIS MOMS, and Medicaid for pregnant women. A combination of DMAS and contractor staff provide callers with information and assistance in completing applications, determine eligibility of children and pregnant women, and enroll eligible applicants in the appropriate program or coordinate with local offices of social services to facilitate enrollment.

PREMIUM ASSISTANCE PROGRAM

The division administers FAMIS *Select,* a premium assistance option available to families with FAMIS eligible children who have access to health plans at their place of employment or through a privately purchased health plan. If eligible, FAMIS *Select* can help a family pay their monthly premiums to enroll in the private/employer's plan instead of FAMIS.

MATERNAL AND CHILD HEALTH SPECIALIZED SERVCIES

Administration of several specialized health care services for children and pregnant women are also within the scope of the division. These include:

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program – a preventive treatment program for children up to age 21 covered by FAMIS Plus/Medicaid by providing periodic comprehensive health screenings and medically necessary specialized treatment to correct or ameliorate diagnosed conditions.
- BabyCare program – to provide services to address conditions that may negatively affect pregnancy and infant health outcomes. The program includes care coordination and supportive services for pregnant women and infants up to age two who are identified as high-risk and are not enrolled in a managed care plan.
- School-based services – to provide physical, occupational and speech therapy, skilled nursing, psychological services, and hearing and EPSDT screenings in the school setting for children with non-acute conditions.
- Family Planning Waiver – to provide family planning services for two years following the birth of a child to women who were covered by Medicaid.
- Children's Mental Health Waiver – to provide community based services to individuals under 21 who have resided in a psychiatric residential treatment facility for at least 90 days. Services in the community include: respite, companion, environmental modifications, in-home residential, therapeutic consultation, and family/caregiver training.
- ABCD – (Assuring Better Child Health and Development) Through this national initiative, DMAS works with managed care organizations, the AAP Virginia Chapter, and other state agencies to promote the use of standardized screening tools as a routine component of well child care for children under three years of age.
- Coordination with other agencies – to promote and monitor services such as lead screenings, Vaccines for Children, WIC, Resource Mothers, Early Intervention Services, etc.

OFFICE OF COMMUNICATIONS AND LEGISLATIVE AFFAIRS

This division coordinates and creates presentations; handles constituent responses for the Office of the Secretary of Health and Human Resources and the Governor; coordinates, tracks and handles legislation affecting the Department; coordinates and handles press calls, media interviews and constituent letters to the Director.

In addition, any request submitted to the Agency by mail, phone, electronic or fax, regarding general information or Freedom of Information Act (FOIA) is handled by the division. Archiving and records retention are coordinated within this division for DMAS.

The Division assists in representing the Department during the annual session of the General Assembly. It tracks the Department's progress in completing the projects originating from legislative direction.

The Division reports on the progress of the assigned tasks and coordinates these efforts with the Management Team. It performs special projects assigned by the Agency Director and Executive Management Team as needed.

The Division serves as the project manager and agency liaison to the property management. The Unit obtains services and materials from commercial vendors when they are required. It works to develop and implement changes necessary for the most cost effective and efficient functioning of Department personnel in their respective office space.

POLICY AND RESEARCH DIVISION

The Policy and Research Division has responsibility for four main areas: eligibility, research and policy analysis, regulatory review, and program development.

ELIGIBILITY

This unit ensures that federal eligibility policy is implemented at the State level. Staff ensure that federal policy is incorporated into the State Plan and that Virginia's laws and policy conform to the federal policy. Staff also provide oversight of the Department of Social Services (DSS) to ensure that eligibility guidelines are correctly implemented at the local level in determining eligibility of individuals for programs that DMAS administers.

RESEARCH, POLICY ANALYSIS, AND POLICY DEVELOPMENT

The Policy Division is responsible for analysis, development, and promulgation of a wide range of policies for the Department. This includes the evaluation of existing policies, the development of new policies, and the interpretation and implementation of federal policies.

The Policy Division is also responsible for designing and conducting studies of various Medicaid-funded programs as directed by the General Assembly, the Governor, Secretary of Health and Human Resources, and the agency director. Based on the research conducted, staff are responsible for the development of position papers, reports, and agency briefing packets.

REGULATORY DEVELOPMENT AND REVIEW

A Regulatory Coordinator oversees regulations and the regulatory process, including the State Plan for Medical Assistance Services and the Title XXI State Plan for the Family Access to Medical Insurance Security (FAMIS) program. The Division is responsible for reviewing and updating Medicaid Memos and Provider Manuals.

PROGRAM DEVELOPMENT

The Policy Division directs the development and implementation of various demonstration projects and grants. The division is the lead in developing new mental health services in coordination with the Comprehensive Services Act and for evaluation of the future direction of mental health care.

LONG-TERM CARE DIVISION

The Long-Term Care Division develops, implements and administers programs designed to improve the lives of the elderly and persons with disabilities. The Division analyzes, develops and promulgates long-term care regulations, policies and procedures, designs and conducts long-term are studies, provides policy and operational support for the long-term care programs of the Department and develops new home-and-community-based waivers.

The Division has three units including: 1) Care-Management Programs 2) Quality Management Review; and 3) Long-Term Care Policy and Quality Initiatives.

Care Management Programs

This unit is responsible for the development, oversight and review of Medicaid long-term care programs (recipients and providers) that have an emphasis on care or case management designed to assure the health, safety and welfare of waiver recipients and the proper expenditure of Medicaid funds. Oversight includes responding to requests for policy interpretation, technical assistance and education to providers, stakeholders and consumers and their families, in developing regulations, policy and procedures. Staff provides training as necessary. Oversight for programs includes:

- Program of All Inclusive Care for the Elderly
- Individual and Family Developmental Disabilities Waiver
- Technology Assisted Waiver

Quality Management Review

This unit is responsible for the development, oversight and quality management reviews for Virginia's Medicaid waivers and home-and-community based programs (recipients and providers) designed to assure the health, safety and welfare of waiver recipients and the proper expenditure of Medicaid funds. Oversight includes responding to requests for policy interpretation, technical assistance and education to providers, stakeholders and consumers and their families, in developing regulations, policy and procedures. Staff provides training as necessary. Oversight for programs includes:

- Elderly or Disabled With Consumer Direction Waiver
- AIDS Waiver
- Mental Retardation/Intellectual Disabilities Waiver
- Day Support Waiver
- Alzheimer's Assisted Living Waiver
- Facility Based Programs including: Nursing Facility, Assisted Living, Rehabilitation, Durable Medical Equipment (policy development and training), Hospice and Home-Care (policy development and training)

LONG -TERM CARE POLICY SUPPORT AND QUALITY INIATIVE UNIT

The Long-Term Care Policy Unit is responsible for long-term care policy analysis, development and promulgation of regulations, for designing and conducting studies, communication with the Center for Medicare and Medicaid Services, responses to long-term care grant opportunities, level of care reviews and the development of quality initiatives for all long-term care programs. The unit:

- Serves as the long-term care point of contact for CMS including the submission of waiver applications, waiver evidentiary packages and revisions to waivers
- Oversight and monitoring of the consumer-directed portion of all waivers

- Develops quality initiatives for all long-term care programs
- Develops updates and keeps current long-term care regulations and policy.
- Develops legislation and tracks legislative issues affecting long-term care services.
- Writes and develops grants to improve the long-term care system.
- Oversees awarded long-term care grants.

DEPUTY DIRECTOR FOR OPERATIONS

Under the Deputy Director for Operations are three separate divisions: Program Operations, Health Care Services and Program Integrity.

PROGRAM OPERATIONS DIVISION

The Program Operations Division provides services for medical evaluation of services including an eligibility and enrollment component, payment processing, customer services, provider training and is responsible for oversight of a provider enrollment contract and a mass-mailing contract.

MEDICAL SUPPORT UNIT

The Medical Support Unit is a federally required critical component of the Medicaid Program. It ensures that medical consultation is available to Department programs and to Department administration, as well as to assure that Peer Review is available to enrolled providers. Some of the responsibilities are: organ transplant preauthorization; providing consultation on complex and high-cost medical, dental and pharmacy issues to the Department administration, Policy Division, Medallion, the Helpline and other Department programs; providing consultation to HMO's on Medical Review and policy matters; providing out-of-state preauthorization and air transportation authorization; providing Peer Review for all Department Contract programs; providing medical edits for scope and limits of service; providing preauthorization for cosmetic and high cost elective surgical procedures; providing review of pended complex surgical, emergency room visits, pharmacy and dental claims. It also provides review of level of care reconsideration for long term care; providing preauthorization of nursing home preadmissions for community based care and preauthorization of high cost drugs and off-label drug uses; providing medical necessity review of MAP-122 (dental) services and preauthorization of dental services (over 21 years of age); providing preauthorization of prostheses; participating in provider and recipient appeals; and assisting in educating providers, recipients, elected officials, and the general public regarding coverage of medical services, policies, criteria and procedures.

PAYMENT PROCESSING UNIT

The Payment Processing Section evaluates, processes, and adjudicates claims and payments for various providers in specific benefit programs. Current programs are Virginia Medicaid, State and Local Hospital (SLH), Temporary Detention Orders (TDO), Out-of-State Non-Participating Hospitals, Non-Resident Alien, Emergency Room Services, MAP-122 Nursing Home Adjustments, and Complex Medical/Surgical Reviews. The functions are as follows:

- Conduct retrospective prepayment review of in-patient, non-participating hospital stays for medical justification of admissions and for psychiatric admissions and length of stay.

- Utilization review of admission and services provided to recipients in the emergency room setting.
- Authorize the dates of service for Non-Resident Aliens that pertain to emergency conditions/illness.
- Coordinate the payment of services provided by hospitals and physicians for Non-Resident aliens using the current payment process.
- Coordinate payment of organ transplants as authorized.
- Coordinate payment and authorization of complex medical/surgical procedures.
- Authorize eligibility and process claims for patients under a Temporary Detention Order.
- Coordinate adjustments of patient pay amounts with the Department of Social Services and nursing facilities.
- Maintain records for all specific programs that contain authorization of services, claims history, and payment process done by the unit.
- Prepare and provide supporting documentation for the Department's position on recipient and provider appeals.
- Serve as educational resource for covered services and claims processing issues.

This unit is also responsible for the monitoring of the claims processing contract with First Health (fiscal agent). First Health is responsible for the research, review, and proper adjudication of provider claims that pend in the system. First Health also refers apparent system problems to the manager of Payment Processing at the Department. The volume of claims on a monthly basis average over 1,600,000 with payments of over $150, 000,000 per month. Approximately 3.5% of Medicaid claims pend for manual review. The functions of the contract monitor are as follows:

- Monitor random samples of fiscal agent's adjudication of pended claims to ensure compliance with all federal and state laws and regulations, as well as Department policies and procedures.
- Develops pend-resolution guidelines and provides assistance with training as needed regarding new edits and audits.
- Provides assistance with training as needed regarding new edits and audits.
- Researches non-routine complex claims issues.
- Manually interfaces with First Health.
- Provides assistance in the review and development of the MMIS relevant to claims processing, centralizing in the area of edits and audits.

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) UNIT

The HIPP Unit (Health Insurance Premium Payment) manages eligibility and payment for insurance premiums. Medicare premium payments are handled through the buy-in process, while HIPP staff handles payment of employer-sponsored insurance for Medicaid eligible as well as those eligible for coverage through a separate funding devoted to HIV assistance through the VaMMIS. HIPP handles approximately 1,200 cases per month with 10% or greater turnover monthly, while HIV assistance covers approximately 100 families per month. Buy-in staff ensures that over 127,000 Medicare enrollees are handled correctly for Medicare premium payment.

CUSTOMER SERVICES UNIT

The Customer Services Unit consists of a supervisor, program representatives, and technical and clerical staff that responds to telephone call inquiries and providers and recipient correspondence.

Activities include:

- Responding to provider and recipient claim and payment inquiries.
- Resolving problems related to claims and recipient eligibility status.
- Resolving unclaimed property problems consisting primarily of lost or unaccounted-for provider checks.
- Managing returned mail for the Department.
- Providing individual billing training to providers.

TELEPHONE CALL CENTER UNIT (Provider and Recipient HELPLINES)

This unit, consisting of the Call Center Supervisor and program representatives, answers provider telephone inquiries and routine provider correspondence. Functions include:

- Responding to provider and recipient telephone inquiries about Medicaid, FAMIS, State/Local Hospitalization and other program policies and procedures.
- Resolving claims/billing problems on-line or taking critical information about claims/billing issues for later response to providers. Staff members compile issues, claims/billing problems, and provider complaints to give feed back to appropriate Department staff for corrective action and policy consideration.
- Performing provider training and on-site assistance as required.

PROVIDER ENROLLMENT CONRACT MONITORING

A Provider Enrollment Contract Monitor oversees the fiscal agent, First Health Services, activities in enrolling and recertifying all Medicaid, FAMIS and SLH providers. The functions are to:

- Receive and process requests for participation in Medicaid, FAMIS, and SLH.
- Maintain and update records on all participating providers
- Recertify providers' status for payment.
- Monitor sanction reports to ensure appropriate provider enrollment status.
- Support documentation needs of the agency regarding provider status.

PROVIDER TRAINING UNIT

The Provider Training Unit coordinates, administers and provides statewide and regional training to participating providers on policies, procedures, and covered services of the programs administered by the Department.

- On an ongoing basis conducts training needs assessments.
- Plans, develops and facilitates presentations.
- Prepares instructors, construct presentations aids, schedules classes, and develops evaluation instruments.
- Maintains and updates the provider Training Plan that includes the timetable and resource requirements.

MASS MAILING CONTRACT
The Department has a contract with Commonwealth/Martin for distributing provider manuals, forms, memorandums and recipient mailings.

The contractor functions include:

- Receiving and processing requests for the monthly mailing of new provider fulfillment packages
- Receiving and processing regularly scheduled monthly mailings to program recipients.
- Responding to special mailing requirements and formats.
- Updating provider and recipient mailing databases.
- Shipping forms and manuals from the Order Desk to replenish provider stocks.

ELIGIBILITY AND ENROLLMENT UNIT
This unit is comprised of various functions that all relate to recipient eligibility and enrollment, and their access into one of several medical assistance programs. The primary characteristics of the unit is to ensure that the automated system, VaMMIS, requirements are appropriate for recipient enrollment in Medicaid and State and Local Hospitalization (SLH); provide enrollment support to the State and Local Departments of Social Services; and respond to complex questions regarding eligibility and enrollment functions. The unit also has oversight of the Uninsured Medical Catastrophe Fund (UMCF). Each program, Medicaid, SLH and the UMCF has separate rules, policies and procedures, and budgets. In addition to these primary functions, the unit also oversees various contracts and Interagency Agreements representing millions of dollars of expenditures, and service delivery system to hundreds of thousand of Virginia citizens.

HEALTH CARE SERVICES DIVISION

The Health Care Services Division focuses on the development, implementation, and administration of managed care, pharmacy, transportation, and quality assurance services provided to eligible Medicaid recipients.

MANAGED CARE UNIT
The Managed Care Unit administers Medicaid through two managed care programs: MEDALLION and Medallion II. Participation in managed care is mandatory for certain Medicaid populations, unless the recipient meets specified exemption criteria as specified in regulations.

MEDALLION is the primary care case management (PCCM) program that operates in 43 localities throughout the Commonwealth through a network of primary care physicians (PCPs) statewide. MEDALLION staff conducts field visits to provider offices to encourage participation in Medicaid and MEDALLION, provide education support, and assist in maintaining program compliance.

The Medallion II program is administered through 7 contracted managed care organizations (MCOs): Anthem Healthkeepers Plus, Anthem Priority, Anthem Peninsula, CareNet, Optima Family Care, Virginia Premier Health Plan, and Amerigroup Community Care. Medallion II operates in 91 localities throughout the Commonwealth.

The Department contracts with an enrollment broker to operate a managed care helpline for the MEDALLION and Medallion II programs. The helpline assists in the development and distribution of educational materials to managed care eligible recipients and enrolls the recipients in a managed care program. The helpline is a toll free number available Monday through Friday from 8:30 a.m. to 6:00 p.m. to answer questions about the managed care programs and to assist recipients in making informed decisions about their health care options.

The Managed Care Unit is responsible for program implementation, monitoring, and oversight of the contracted MCOs for compliance in the provision of medical services to Medicaid managed care and FAMIS eligible individuals. The Managed Care Unit ensures compliance with Federal and State regulations, addresses Federal and State legislative issues affecting managed care, and places emphasis on provider network analyses to ensure adequate and accessible care in the managed care communities. The Managed Care Unit also works in conjunction with other areas in improving the health outcomes of recipients. Through its managed care programs, the Department has been successful in increasing provider access, improving patient satisfaction, improving health outcomes, and reducing/containing costs in the Medicaid population.

PHARMACY UNIT

The Pharmacy Unit supports the administration of pharmacy programs and services for fee-for-service recipients. The Unit manages the following functions:

- Program design and issue resolution related to on-line claims processing of prescription claims
- Monitoring of drug utilization through prospective and retrospective claims review
- Ensures accuracy of data submitted and rebates collected from drug manufacturers for the CMS Federal Rebate Agreement.
- Directs the operations and program design of the Preferred Drug List including contract management, support of Pharmacy and Therapeutics (P&T) Committee, clinical call center operations, systems integration, and the supplemental rebate process
- Directs the operations and program design of the Maximum Allowable Cost (MAC) program including contract management, dispute resolution process, systems integration, as well as monitoring related drug pricing and cost savings
- Directs the operations and program design of the Behavioral Pharmacy Management System (BPMS) program.
- Support of various pharmacy advisory groups including the Drug Utilization Review (DUR) Board and Pharmacy Liaison Committee.

TRANSPORTATION UNIT

Medicaid provides all transportation to covered services for fee-for-service recipients who cannot drive or have no vehicle available. Non-emergency transportation is provided through a broker who preauthorizes the trip and assigns it to a provider who transports the recipient by car, wheelchair van, stretcher van or ambulance. In 2006, about 3,500,000 trips were provided for fee-for-service recipients to get medical appointments, dialysis, mental health and mental retardation programs, and other covered services. Emergency transportation is provided when necessary by emergency ambulance, air ambulance, and to specialized medical care in other states.

SMILES FOR CHILDREN PROGRAM

The *Smiles for Children* program provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services for Medicaid, FAMIS and FAMIS Plus children. In addition, the program provides coverage for limited medically necessary oral surgery services for adults (age 21 and older). Doral Dental USA is the single dental benefits administrator (DBA) that will coordinate the delivery of all Smiles For Children dental services.

*Smiles for Children e*nrollees receive dental benefits with easier access to participating dentists. Enrollees may only use dental providers enrolled in *Smiles For Children.* There are no enrollee costs to receive dental care services in *Smiles For Children*.

SYSTEMS AND REPORTING UNIT

The Systems & Reporting Unit provides technical and operational support for the Health Care Services Division. This unit provides scheduled and ad hoc data reporting that is required for decision support and policy development within the Division and the Department.

In addition, the Systems & Reporting Unit provides oversight and monitoring of performance reporting and contract compliance for the Managed Care Organizations (MCOs). This Unit also manages the External Quality Review Organization (EQRO) in their performance of focused studies, on-site monitoring, and preparation of annual reports on quality for the MCOs, Dental, and Transportation vendors.

The Systems & Reporting Unit is also responsible for the Department's disease management program. The goal of the disease management program is to improve patient quality of care and to slow the growth of health care costs associated with certain chronic conditions.

PROGRAM INTEGRITY DIVISION

RECIPIENT MONITORING UNIT

The Recipient Monitoring Unit administers the Client Medical Management Program (CMM), which is a case management and utilization control program for recipients who overuse Medicaid services.

- The purpose of the program is to:
  - control over utilization of Medicaid services by recipients through coordination of services by a primary health care provider and one designated pharmacy; and,
  - modify the recipient's utilization patterns through education on the appropriate use of services.
- Staff conducts utilization reviews to identify recipients who meet program criteria for over utilization of any Medicaid service such as physician services, prescription drug services, transportation, and emergency room services. Recipients suspected of drug diversion are referred to the Virginia State Police Drug Diversion Unit for investigation.
- This unit is also responsible for maintaining the recipient section of the Client Server Surveillance and Utilization Review system, commonly known as CS-SURS. CS-SURS profiles Medicaid recipient and provider activity using claims-based data from MMIS. CS-SURS reports are used to identify recipients who are high users of Medicaid services.

PROVIDER REVIEW UNIT
The Provider Review Unit's main function is to identify and review providers who may be practicing abusive or fraudulent billing to the Medicaid Program.

- Providers are identified through the Client Server Surveillance and Utilization Review system (CS-SURS). Those providers who are billing a higher than average number of services in comparison to their peers are opened to an Integrity Review.
- The Provider Review Unit currently conducts desk and on-site audits of medical records.
- Corrective action plans are then developed based on the audit findings. Actions taken as a result of the review include:
  - close to no abuse
  - educational contact via letter to the provider, or,
  - requesting the provider to repay the established overpayment to the agency identified in the audit findings.
- Any audit findings that show possible fraudulent activity are referred to the Medicaid Fraud Control Unit at the Office of the Attorney General.

RECIPIENT AUDIT UNIT
The Recipient Audit Unit is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid, FAMIS and State and Local Hospitalization (SLH) Programs, which result in misspent funds expended by the Department of Medical Assistance Services. These allegations typically involve misspent funds involving recipient eligibility issues such as: deceit in application, illegal use/sharing of a Medicaid card, uncompensated transfer of property, excess resources or income, and fraudulent household composition. The Unit also investigates drug diversion and performs joint investigations with law enforcement, Virginia State Police, Social Security, the FBI, and other federal/state agencies.

The Recipient Audit Unit recovers overpayments due to recipient fraud and abuse and also tries to prevent and deter future losses through the following dispositions of their investigations:

- Administrative recovery from recipients of the overpaid benefits loss
- Criminal prosecution of recipient fraud, and related penalties, sanctions and restitution as ordered by the courts

MENTAL HEALTH/CONTRACT MANAGEMENT UNIT
This unit has the programmatic responsibility for mental health services and conducts utilization reviews for mental health services, residential treatment facilities and treatment foster care. The unit also provides technical assistance to providers of mental health services and annually conducts training on Community Mental Health Services for the providers of these services. Lastly, the unit monitors the Kepro contract and the Comprehensive Services Act (CSA) services that relate to the Medicaid program. The Kepro contract provides preauthorization for many Medicaid services, which include in-patient hospital stays, intensive and outpatient rehabilitation, behavioral health, home health, durable medical equipment, and waivers.

HOSPITAL PREAUTHORIZATION AND UTILIZATION REVIEW UNIT
This unit conducts utilization reviews for acute care hospitals and validates diagnosis related groups (DRGs), the method by which acute care hospitals bill. They conduct reviews of diagnosis and procedure codes submitted on the claims, which is compared to patients' medical record documentation to prevent hospitals for upcoding. This unit also does preauthorization for outpatient psych visits.

DEPUTY DIRECTOR FOR FINANCE AND ADMINISTRATION

There are five (5) separate divisions under the Assistant Director for Finance and Administration: Fiscal and Purchasing, Information Management, Budget and Contract Management, Provider Reimbursement, and Appeals.

FISCAL AND PURCHASES DIVISION

The Fiscal and Purchases Division provides accounting, reporting, and financial management services to the Agency. The accounting functions are in compliance with relevant laws, regulations, fiscal policies and procedures, and professional standards.
The Division develops and operates financial systems with sufficient internal control to provide accurate, timely, and meaningful financial and operating information to all interested parties and to protect the Department against theft and other types of loss. The Division is responsible for financial reporting, disbursement, cash management, third part liability, purchasing and support operations, and financial system administration. The Controller performs general administrative functions; develops and maintains fiscal policies and procedures; develops, implements and uses major automated systems; and provides overall planning and guidance for the Division. The Division coordinates actions with the following groups:

- The Budget and Contract Management Division to control department, division, and grant expenditures.
- Internal, State and Federal auditors, to ensure the safeguarding of Department assets and effective communication with the auditors.
- The State Comptroller and State Treasurer, to ensure compliance with State requirements and the complete processing of DMAS transactions in central systems.
- The Federal Departments of Health and Human Services, Centers for Medicare and Medicaid Services, Family Support Administration, and the Office of Refugee Resettlement, to obtain funding and maintain compliance with Federal requirements.
- Department management, division, units, sections, and employees, on financial matters.

FINANCIAL REPORTING UNIT

The Financial Reporting Unit maintains general and subsidiary ledgers and is responsible for all federal and state reporting. The Department owns and operates an internal accounting system (Oracle Governmental Financials), a fixed asset system, 1099-tax system and various Oracle and Access databases. Oracle Government Financials serves as a "front end" for entering batches into the Commonwealth Accounting and Reporting System (CARS) that prints the Department's checks and provides customized reports.

This Unit prepares numerous internal and external reports including financial, statistical, and compliance information. The following reports are prepared: CMS 64, CMS 21, Payment Management System Report, and the annual Department Financial Statement. The Auditor of Public Accounts examines Department reports and records under the Federal Single Audit Act.

DISBURSEMENT UNIT

The Disbursement Unit processes $3 billion expenditures a year. This includes payment of vendor and provider invoices, interagency vendor payments and pass through transaction, travel expense reimbursement, certification of payroll, and petty cash payments. The Unit provides administrative support for non-Medicaid programs, special programs, and other activities, including:

- Indigent Health Care Trust Fund
- MHMR-Community Medicaid Initiatives
- Indirect cost allocation
- Activity-based cost management and
- Prelisting of cash receipts

CASH MANAGEMENT UNIT

The Cash Management Unit manages cash receipts, accounts receivable, Federal grants, and interagency agreements. The cashier records and deposits Department cash receipts, except for electronically deposited Federal funds. The cashiering function records deposits, classifies receipts, and captures data needed by the Grants Accountant for compliance with the Federal *Cash Management Improvement Act of 1990.* The Disbursement staff process the prelists (recording of cash receipts received in the daily mail) to ensure segregation of the prelist duties from the deposit of cash receipts. Accounts Receivable staff manage collection of accounts, submit past-due accounts to the State's debt offset process, and report on outstanding receivables.

The Grants Accountant monitors reimbursable expenditures and draws Federal funds in accordance with State and federal requirements. The Department administers the following grants:

- Medical Assistance Program (Medicaid Title XIX)
- Family Access to Medical Insurance Security Title XXI (FAMIS)
- Ryan White Fund (HIV Assistance)
- Refugee Grant

THIRD PARTY LIABILITY UNIT

The Third Party Liability Unit is responsible for auditing and correcting claim payments related to hospital Quarterly Credit Balance Reporting. They also investigate and recover funds paid by DMAS from recipients' Estates, Special Needs Trust accounts, and Annuity Policies.

This unit performs investigations to find "third party resources" that result when Medicaid (the payor of last resort) pays medical costs that a third part should have paid. Recovers third-party resources and performs "cost avoidance" activities to prevent Medicaid overpayment. Through an external contractor, Health Management Services (HMS), the unit identifies other third party resources that are liable for payment for service through data matches with Commercial Insurance companies and Medicare.

PURCHASING AND SUPPORT UNIT

This Unit is responsible for the purchase of goods, services and supplies needed by the Department. This includes the administration and processing of purchase orders. Procurements are processed and administered based on the policies and procedures established by the Commonwealth's Department of General Services, and federal and State law. Purchase orders are based on Division Directors' requests and entered into eVA and Oracle Financials; administers the Small Purchase Charge Card Program for the Department; and, maintains office supplies; telephone systems, mail and state vehicle request and services.

INFORMATION MANAGEMENT DIVISION

The Information Management Division (IM) is responsible for the development, implementation, and maintenance of all computer software systems within the agency as well as the procurement, maintenance, and operation of computer equipment. Much of the work is performed in tandem with First Health Services Corporation, which has been the Agency's fiscal agent since 1972. Under DMAS' direction, First Health designs, develops, and maintains the agency's Medicaid Management Information System (MMIS). It is a federal requirement that a state have a certified MMIS in order to receive federal financial participation for its Medicaid program: the Centers for Medicare and Medicaid Services (CMS) certified the system unconditionally on May 20, 2004. IM has two main supporting sections: the Computer Operations Section and the Systems Development Section.

The Systems Development Section:

- Administers the fiscal agent contract with First Health.
- Oversees maintenance of the MMIS.
- Collaboratively with other DMAS divisions and with external entities, such as the Department of Social Services, coordinates systems-development projects for the MMIS.
- Supports other divisions' data needs.
- Assists users in understanding system functions, including programmatic and documentation interpretation.
- Provides advice, guidance, and solution choices to users for systems support for operating functions.
- Implements and maintains the electronic transaction standards issued by the federal Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996.
- Develops and implements enhancements to the DMAS web site as part of the Governor's effort to make Virginia a national leader in E-government.
- Works with VITA on data processing matters within that agency's scope of responsibilities.

Mission Statement:

To develop, operate, and maintain the technology infrastructure needed to support the business strategies, information needs, and operations of the Department of Medical Assistance Services (DMAS).

Computer Operations and Engineering Section
This function consists of the information technology (IT) operations, acquisition, maintenance, and system administration of the DMAS Computer/Data Center, the internal and external data communications networks, and the gateways to remote computer systems (Fiscal Agent, VITA, and other state agencies). This is performed through the following tasks:

- Delivery of services and products to end-users through the operation, testing, and troubleshooting of the IT systems in the DMAS Computer Center and network communications links.
- Provides engineering analysis, and installation of hardware, software, and network systems.
- Resolves Computer software and hardware problems.
- Provides a central system problem resolution/management via Help-Desk support.
- Provides Technical Support for Personal Computers, LAN file servers, super minicomputers, telecommunications, and networks.
- Provides Technical Support for all IT enhancements.
- Maintains the computer/Data Center operations.
- Authorizes logical security access to information systems.
- Establishes security plans, procedures, and implements security policies for compliance with VITA's policy/standards and HIPAA regulations.
- Participates in the Business Impact Assessment and the IT risk analysis/assessments.
- Develops the Disaster Recovery Plan for incorporation into DMAS' Continuity of Operations (COOP) Plan for DMAS' IT systems.
- Develops the Information Management Division budget, which supports and centralizes the entire DMAS IT budget requirements.
- Acquires the necessary hardware, software, and services to meet the IT support role within DMAS.

BUDGET AND CONTRACT MANAGEMENT DIVISION

The Budget and Contract Management Division is responsible for developing and managing the Department’s budget, submitting the Department’s budget to the Department of Planning and Budget (the Agency responsible for managing the entire state Government Budget) and the federal Centers for Medicare and Medicaid Services, and developing and tracking the Department’s strategic plan.

FORECASTING AND PLANNING UNIT
The Forecasting and Planning Unit is responsible for developing the agency’s forecast of future Medicaid expenditures and enrollment. The unit gathers data of monthly level expenditures, utilization and enrollment and inputs these into industry accepted forecasting methods to develop a forecast of future Medicaid expenditures. Forecasts are also developed for some of the Department’s other programs, including FAMIS, the regular assisted living program and the involuntary mental commitment fund.

The Forecasting and Planning Unit is also responsible for developing cost estimates for initiatives considered during budget development for the Governor's budget. The Forecasting and Planning Unit along with the Budget Unit is responsible for developing fiscal impact statements during the General assembly session. Fiscal impact statements describe the impact, and projects costs, of any bills submitted during the General Assembly session that would affect the Department's budget.

The Forecasting and Planning Unit is also responsible for updating the agency's strategic plan and performance measures. The Unit develops recommendations regarding critical issues and agency priorities. The Unit then incorporates these items into a plan with goals, objectives and strategies. It meets and coordinates with members of the Management Team to develop and update the plan, ensuring their priorities and requirements are integrated into the process.

BUDGET UNIT

The Budget Unit is responsible for developing Budget amendments, as directed by the Department Director, for potential inclusion in the Governor's Budget. It also is responsible for submitting to the Department of Planning and Budget the Department's annual budget submission. This includes the most current forecast and any budget amendments approved for submission by the Department Director and the Office of the Secretary of Health and Human Resources. In addition every quarter, the Budget Unit submits to CMS an updated Medicaid expenditures forecast (the CMS 37 report) and an updated FAMIS expenditure forecast (the CMS 21 report). The Budget unit makes administrative adjustments to the Department's appropriation throughout the fiscal year.

The Unit prepares the administrative budget allocation and works with the Director's Office and the Management Team to distribute the Department's administrative funding by cost center, or divisions, to ensure there is adequate funding to administer the program and implement initiatives as needed.

The Budget Unit works with the Fiscal Division to ensure that the agency does not spend more than the available appropriation for each budget program. The Unit is responsible for preparing monthly and quarterly reports comparing expenditures to budget. The Unit also works to develop year-end reports for in the agency's statistical record.

CONTRACT MANAGEMENT UNIT

The Contract Management Unit directs the agency procurement activity and directs the development of Requests for Proposals (RFP) and Invitations for Bids (IFB), contract preparation, solicitation evaluation processes, contractor selection and contract performance reporting. It also manages and monitors Interagency Agreements, including performance reporting, and the agency building contracts and leases, renewal negotiations and makes recommendations to the agency Director. This unit oversees agency energy management, parking, security and the AMEX Purchase Card administration.

PROVIDER REIMBURSEMENT DIVISION

The Provider Reimbursement Division is responsible for setting provider Fee for Service (FFS) rates for many acute and long-term care services, for setting capitation rates for managed care programs, and for settling and auditing institutional provider cost reports.

FFS RATE SETTING UNIT

The unit is responsible for the agency's rates for many FFS services. This includes calculation of rates, developing policy proposals and modeling their impact, implementing policy changes directed by decision makers, providing analysis to support decision-making, and working with contracted firms to complete rate setting related work. Some waiver cost effectiveness responsibility also falls to this unit. Services whose reimbursement falls under the unit include:

- Inpatient hospital
- Hospice
- Rehabilitation
- Indigent care at state teaching hospitals
- Physician
- Nursing homes
- Personal care and waiver
- Home health

MANAGED CARE RATESETTTING UNIT

The unit has the same kinds of rate setting responsibilities as the FFS rate setting unit, but is responsible for managed care services, including:

- Prepaid (capitated) managed care
- Prepaid (capitated) long-term managed care
- Program for All-inclusive Care for the Elderly (PACE)

In addition, the unit is responsible for the agency's efforts to ensure that the state obtains the maximum federal funding possible through the Medicaid program. These programs include:

- Assisting with reimbursement for school based services
- Administrative claiming
- Family planning claiming
- Supplemental payments

COST SETTLEMENT AND AUDIT UNIT

The unit is responsible for cost report related activities of institutional providers who file cost reports. Cost reports must be settled to ensure correct reimbursement for past years, and for some providers, the rate for the coming year is set based on the settled cost of the past year. The unit is also responsible for field audits to ensure that reported costs are correct and consistent with the agency's reimbursement principles. Providers that file cost reports include:

- Hospitals
- Nursing Homes
- Outpatient rehabilitation agencies
- Intermediate care facilities for the mentally retarded
- State psychiatric hospitals
- Federally qualified health centers
- Rural health clinics

APPEALS DIVISION

The Appeals Division provides a process by which clients and providers can appeal adverse decisions made by the Department or its contractors. The basic function of the appeals process is to give clients and providers an opportunity to be heard. The end result of the appeal is a written decision. The Appeals Division has separate units that handle client appeals and provider appeals.

CLIENT APPEALS UNIT

Client appeals involve issues regarding eligibility and medical services. If a person applies for Medicaid or another program administered by the Department and is determined to be ineligible, that person can request an appeal of the eligibility determination.

If a person already eligible for Medicaid or another program administered by the Department is denied a request for a particular medical service, that person can request an appeal of the denial of the medical service. There is only one level of administrative appeal, which is an evidentiary hearing before a hearing officer employed by the Department. Federal regulations mandate that most client appeals be processed within 90 days, including conducting the hearing and issuing a decision. Title 42 of the Code of Federal Regulations at Subpart E (§431.200 through 431.250) contains the federal requirements for fair hearings for applicants and clients of Medicaid. The Department also has regulations addressing client appeals in the Virginia Administrative Code at 12 VAC 30-110-10 through 12 VAC 30-110-380.

Client appeal decisions can be appealed to court for judicial review of the record, and therefore, part of the administrative appeal function is to maintain an accurate and complete copy of the record of the administrative proceeding, including the decision and all exhibits as well as the transcript of the hearing. The first level of court review is circuit court, then the Virginia Court of Appeals, and then by petition to the Virginia Supreme Court.

PROVIDER APPEALS UNIT

Provider appeals involve issues regarding reimbursement to health care providers for medical services that have already been provided. Provider appeals involve every type of provider with which the Department contracts, including physicians, hospitals, nursing homes, and adult care residences, home health agencies, durable medical equipment suppliers, pharmacists, etc.

If a provider has rendered services to a client enrolled in Medicaid or another program administered by the Department and has either been denied reimbursement for the services or has received reduced reimbursement, that provider can request an appeal of the denied or reduced reimbursement.

There are two levels of administrative appeal: The informal appeal, (also known as the informal fact finding conference), and the formal administrative appeal.

The informal appeal is conducted by an informal appeals agent employed by the Department. At the informal appeal level, the Department's informal appeal agent conducts a fact-finding conference, considers all documentation submitted by the parties and recommends an informal decision that is issued from the Appeals Division. Virginia law mandates that provider's informal appeal be processed within 180 days. The provider is not bound by the decision and may request a formal administrative appeal.

The formal administrative appeal is presented before a hearing officer appointed by the Executive Secretary of the Supreme Court of Virginia. An administrative hearing representative employed by the Department presents the Department's position. The Supreme Court hearing officer writes a recommended decision for use by the Director of the Department in issuing the Final Agency Decision. The Department must issue its Final Agency Decision within 60 days of receiving the hearing officer's recommendation. The Final Agency Decision can be appealed to court for judicial review of the record, and therefore, part of the administrative appeal function is to maintain an accurate and complete copy of the record of the administrative proceeding, including the decision, documentary evidence, motions, briefs, exceptions, as well as the transcript of the hearing. The first level of court review is Circuit Court, then the Virginia Court of Appeals, and then by petition to the Virginia Supreme Court.